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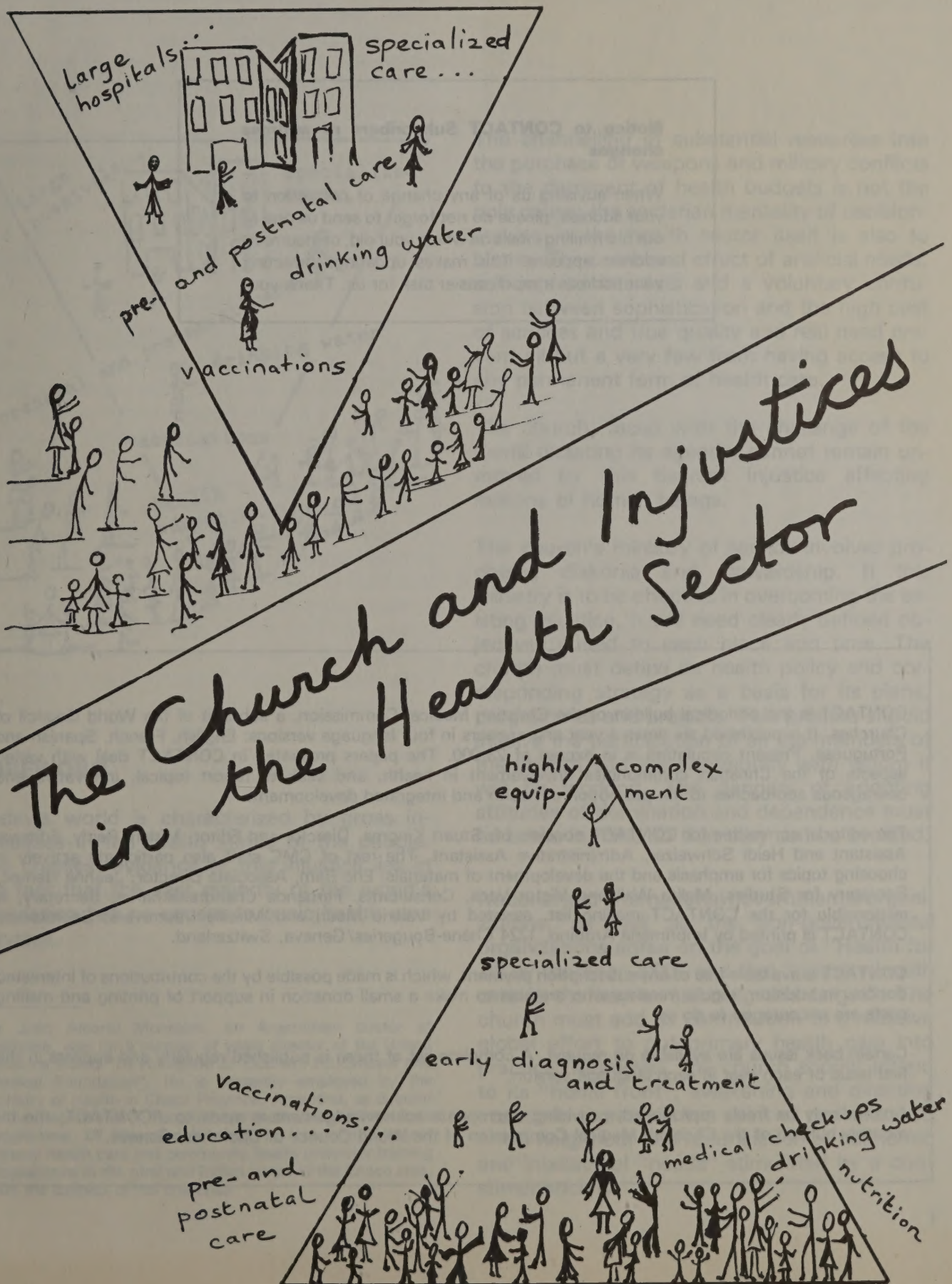

The Church and Injustices in the Health Sector

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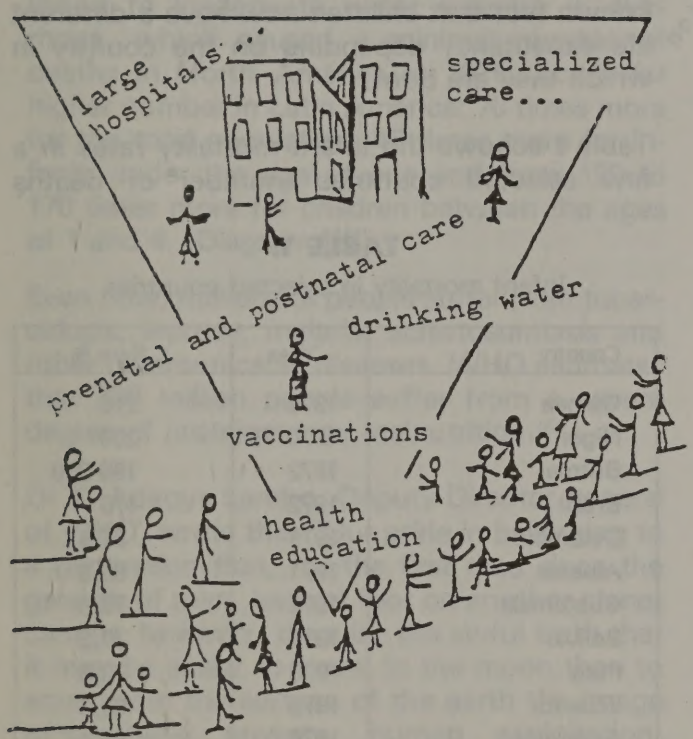
THE CHURCH AND INJUSTICES IN THE HEALTH SECTOR

Julio Alberto Monsalvo*

Illustrations: Inés Ricci de Monsalvo



FOREWORD

Today's world is characterized by gross inequalities in the health status of the people. The cruellest evidence of this injustice lies in the fact that the vast majority of the world's population has no access to basic health care services.

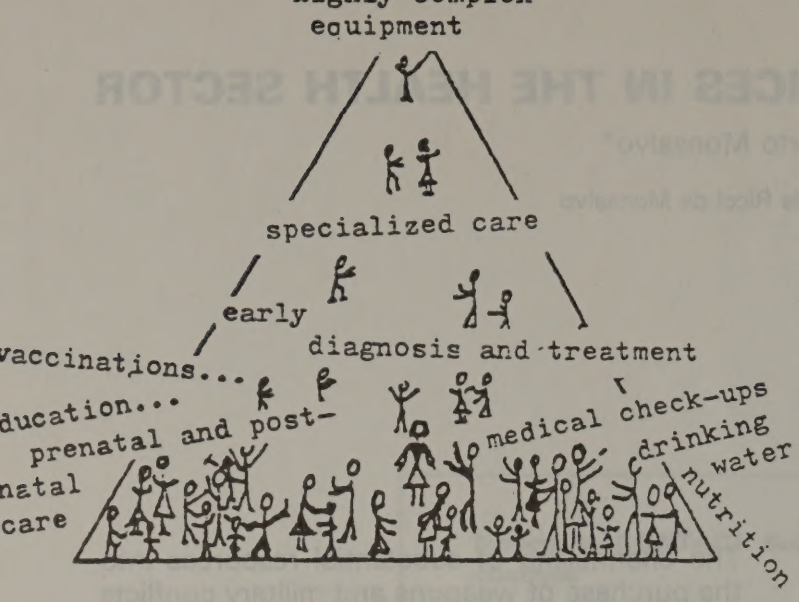
The channelling of substantial resources into the purchase of weapons and military conflicts to the detriment of health budgets is not the only cause; the sectarian mentality of decision-makers in the health sector itself is also to blame. The combined effect of artificial needs, self-centred interests and a voluntary confusion between sophistication and the high cost of services and true quality and real need prevent all but a very few from having access to any permanent form of health care.

The church, faced with the challenge of the world dictating its agenda, cannot remain unmoved by this flagrant injustice affecting millions of human beings.

The church's ministry of service involves prophecy, diakonia and stewardship. If this ministry is to be effective in overcoming the existing injustice, it will need clearly defined objectives suited to each place and time. The church must define its health policy and corresponding strategy as a basis for its plans, programmes and projects. This process should involve the participation of all the members of the church and the community *with* whom it will be working. The dangers of adopting attitudes of domination and dependence must be borne in mind so that they can be avoided.

National and international governmental organizations, as well as the non-governmental organizations agree on the goal of "Health for All by the Year 2000" and that "primary health care is the key to attaining this target". The church must add its contribution to a massive global effort to put primary health care into practice. Moreover, the church should attend to its "home front", awakening and directing vocations to service in a spirit of dedication to one's neighbour and renunciation of economic and intellectual "needs" stimulated by a consumer society.

*Dr Julio Alberto Monsalvo, an Argentinian doctor of medicine, was for a number of years director of the United Missions Board "Dr Humberto E. Cicchetti Educational and Medical Foundation". He is presently employed by the Ministry of Health in Chaco Province, Argentina, as director of the hospital and of the provincial headquarters of the Area Programme. Dr Monsalvo has built up one of the largest primary health care and community health promotor training programmes in the rural and Indian zones of the Chaco area, with the support of the churches.



INTRODUCTION

Health can be understood as a condition of wholeness on both the personal level and in society; as a state of complete physical, mental and social wellbeing. What occurs within the individual has repercussions on the entire community and its environment. Human beings naturally aspire to health. It is a question of the life in abundance of which our Lord speaks.

The church has traditionally been concerned and involved with the people's health; it has a commitment to the whole bio-physico-social person in his/her historical context; it has undertaken, and still is undertaking, multi-faceted activities in the field of health care. The church cannot remain indifferent to the problem of global health as we enter the last two decades of this century. It is impelled to act by its tradition of service and the central theme of Biblical thought, "You shall love your neighbour as yourself". Sinful structures cannot but spawn *injustices,* which are manifested by sickness and the inability of millions of human beings to care for their health. How are we to respond to this global cry for greater justice in health?

When we talk of the "church", we include all those who are discovering God through service and dedication to people as neighbours without necessarily belonging to any particular Christian church.

I. HEALTH SITUATION AT THE END OF THE TWENTIETH CENTURY

The global health situation as we enter the final years of the twentieth century could hardly be more discouraging. The contrast between scientific and technical advances and poverty and misery is increasingly stark. There are obvious inequalities in the health status of peoples in different countries and in different sociocultural strata and geographic regions within each of these countries. Those who live in poor countries do not have the same health opportunities as the inhabitants of rich countries. The same inequalities affect people living in geographically remote areas, ethnic minorities and vast sectors of society that do not enjoy proper living conditions, even in the so-called developed countries. It is a well-known fact that children now have a different life expectancy depending on the country in which they are born.

Table I schows the infant mortality rates in a few selected countries (number of deaths

TABLE 1:

Infant mortality in selected countries

Country	Year	Rate %
Guinea	1970	216
Niger	1970/75	200
Burma	1972	195-300
Brazil	1972	170
Colombia	1976	88,9
Albania	1971	86,8
Guatemala	1976	76,5
Bolivia	1976	77,3
Peru	1973	70,3
Ecuador	1975	65,8
Argentina*	1976	44,4
Portugal	1976	38,9
Yugoslavia	1977	35,2
Panama	1977	28,5
Cuba	1976	22,9
USSR	1977	27,7
Jamaica	1976	20,4
Puerto Rico	1977	18,5
Canada	1977	14,3
Australia	1977	14,3
United States	1977	14,0
New Zealand	1976	13,9
Hong Kong	1977	13,9
Lebanon	1977	13,6
Holland	1977	9,5
Denmark	1977	8,9
Japan	1977	8,9
Sweden	1977	8,0

*Public Health Department, Argentina.

Source: Population and Vital Statistics Report, data available as of January 1979; Series A. Vol XXX No. 1.

among infants under the age of one per 1000 live births).[1] The provision of water in terms of quantity and quality is insufficient for millions of human beings. WHO estimated that in 1975, some 1230 million people (out of a total population of 2000 million) in the "developing" world lacked adequate water supplies. The situation is even more serious for the rural population. In rural areas, only 22% had access to community water.[2]

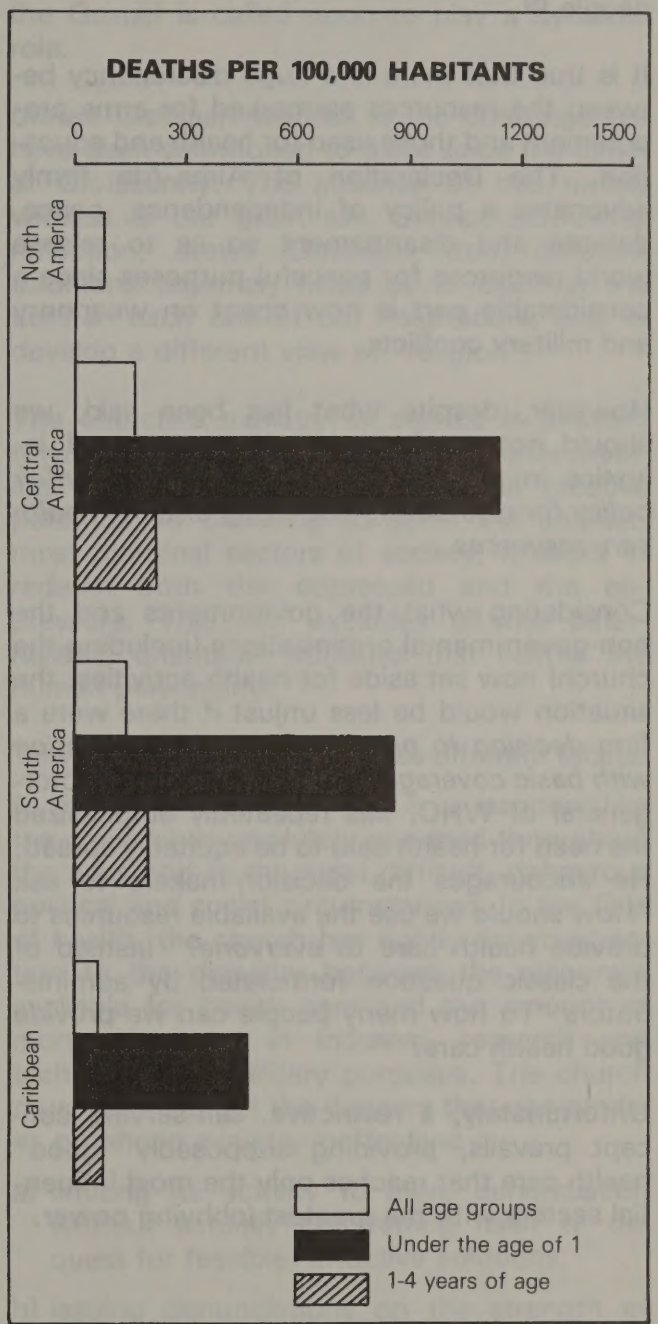
Anyone who has ever lived in an area where water is scarce can grasp the full magnitude of the problem. One of the diseases most closely linked to inadequate water supplies is diarrhoea, which caused a minimal number of deaths in North America in 1975, but a far higher number in Latin America: 70 times more for the total population, 45 times more for infants under the age of one and from 120 to 170 times more for children between the ages of 1 and 4. (Diagram 1)[3].

Even now, millions of people suffer from tuberculosis, leprosy, malaria, schistosomiasis and other communicable diseases. WHO estimates that 700 million people suffer from a severe degree of proteinenergy malnutrition.[4]

Dr T. Adeoye Lambo, Deputy Director-general of WHO, wrote that "Our pride in belonging to a generation that, for the first time since the genesis of man, has set foot on another planet cannot, however, disguise the awful truth that it may be easier to travel to the moon than to erase from the surface of the earth the image of inevitable poverty, human exploitation, injustice and the degredation of human welfare."[5]

Diagram 1

Deaths from enteric infection and other diarrhoeal diseases per 100,000 inhabitants under the age of 1 and between 1 and 4 years of age. Americas, 1975.



Source: Panamerican Health Office Bulletin, May 1979.

II. ACCESS TO HEALTH SERVICES

The cruellest aspect of injustice in health can be seen in the present coverage of health services. The World Health Organization and the United Nations Children's Fund held an International Conference on Primary Health Care in Alma-Ata, USSR, in September 1978, which was attended by member countries and the non-governmental organizations involved in health care (including the WCC's Christian Medical Commission).

The final document, known as the "Declaration of Alma-Ata", affirms that four-fifths of the world's population has no access to *any* permanent form of health care.[6] It similarly stresses another unquestionable fact, namely, that millions of people are *disenchanted* with the service provided by conventional health systems.

The problem of inequalities in the health sector goes hand in hand with other injustices that permeate every aspect of human activity. It has been predicted that the present world population of 4000 million will double in the next three decades.[5] Unless the world awakens to this

reality and reacts, the gap will widen. At least three-quarters of the world's income, investments, services and almost all of the world's research are in the hands of one quarter of its people. [5]

It is true that there is a huge discrepancy between the resources earmarked for arms procurement and those used for health and education. The Declaration of Alma-Ata firmly advocates a policy of independence, peace, detente and disarmament so as to release world resources for peaceful purposes since a considerable part is now spent on weaponry and military conflicts.

However, despite what has been said, we should not overlook a serious aspect of injustice in the health sector itself: *the unfair policy for distributing and using existing health care resources.*

Considering what the governments and the non-governmental organizations (including the church) now set aside for health activities, the situation would be less unjust if there were a firm *decision to provide the entire population with basic coverage.* Halfdan Mahler, Director-general of WHO, has repeatedly emphasized the need for health care to be equitably spread. He encourages the decision-makers to ask "How should we use the available resources to provide health care to *everyone*?" instead of the classic question formulated by administrators "To how many people can we provide good health care?" [4]

Unfortunately, a restrictive, self-serving concept prevails, providing supposedly "good" health care that reaches only the most influential sectors with the greatest lobbying power.

III. CAUSES OF INJUSTICES IN THE HEALTH SECTOR

Only a few have access to health services and receive the questionable benefit of complex, costly means of diagnosis and treatment. Vast numbers have no permament access to any basic health service, are born and die without any type of care, live their lives without a single medical check-up or vaccination. We shall not attempt to make a comprehensive analysis of all the reasons why decision-making centres have adopted this highly sectarian way of thinking that benefits a chosen few. We shall merely underscore a few of them:

1. *Medical industry:* The medical industry has created expectations and artificial needs. In the past few decades, it has managed to establish a consumer market for sophisticated apparatus and complex technology. This market comprises not only the medical profession but also the public at large. A mistaken belief that sophistication and high cost is a guarantee of quality has been forced on the people.

The medical profession feels intellectually bound to master complex technology, tends to specialize and the personal, family relationship between doctor and patient rapidly disappears. Society, for its part, lends greater status and social prestige to those who practise what can be described as "spectacular" medicine.

This is all to the detriment of the personal care that is absolutely necessary if treatment is to be genuinely successful. Moreover, few attend to basic health services which call for relatively unsophisticated action that costs less, is of optimal quality and vital importance but is neither spectacular nor financially rewarding.

Complex equipment and operations that are not always necessary, innocuous or even satisfactory for the patient offer the medical profession these very attractions.

2. *Pharmaceutical industry:* The pharmaceutical industry has managed to create a form of "drug addiction" among the medical profession and the people by means of subtle incentives. The medical profession is encouraged to over-prescribe. What is more serious is that commercial propaganda has blunted its ability to make scientific decisions. The patients themselves demand drugs as the logical, necessary outcome of any visit to the doctor. People often indulge in irrational self-medication directly or indirectly suggested by the media or pseudo-scientific notes on a new medical product, apparently adressed to the medical profession, or "solidarity campaigns" to obtain a given make of drug for a patient with slim resources.

A survey carried out in Argentina in 1970 revealed that 50% of the total amount spent by the population on health care was used to purchase drugs. At the same time, the price of drugs truly prevents large sectors of the population from having access to health services.

It is also true that multinational laboratories market certain products for long periods of

time in the developing world, long before obtaining the authorization to do so in the wealthier countries.

3. *University training:* "Scientism" predominates in university education. The result is professional elitism, an inability to delegate responsibility, a reluctance to train other levels and, what is most tragic, the loss of a humane approach. The physician does not view the patient as a total human being but, on the contrary, as the *object* of his examination and medical praxis.

Those of us who work in the field of church-related health care have also been trained in, and conditioned by, this approach.

4. *Profit-oriented private medical practice:* This system offers every possible opportunity to forget about the interests and needs of the people and total health care and to place profits at the top of one's scale of values. Increasingly costly equipment and practices (that are really for a tiny number of diseases and patients) are improperly and unnecessarily used for allegedly "scientific" reasons which are actually designed to mask the real aim of exorbitant earnings.

Many professionals believe they are entitled to a far larger income than the rest of the population simply because they have a university degree.

Young people's vocation to serve their fellow-beings in one of the fields of health is gradually fading as they are caught up in a competitive society that fills their minds with obsessive ideas about large profits as an end in themselves and a source of prestige and power.

The underworld of medicine is characterized by tricks and swindles as well as the improper use of risky, unwarranted practices.

5. *Personal and sectoral outlook:* It is common to observe that in both governmental and non-governmental spheres, resources are used to meet needs which do not correspond to the situation of the people. The decision as to the use of such funds is strongly influenced by the desire to satisfy various intellectual concerns, scientific curiosity, psychological needs (e.g., for prestige) and even economic interests.

Veritable "fiefs" are thus created in hospitals, universities and institutions.

IV. FACETS OF THE CHURCH'S MINISTRY

The church, as the custodian of the message of the Gospel is called upon to play a dynamic role.

United Christian witness is the challenge we have been summoned to meet since the dawn of Christianity. The absence of this united witness is our great sin. Service stimulates reflection, draws Christians from different traditions together, helps us to discover the Lord in each one of our neighbours, and to develop a different view of "religion".

The churches ministry of service is directed toward HUMAN PROMOTION, towards enabling humankind to develop its full creative potential. In choosing to serve the poorest, most marginal sectors of society, it seeks to redeem both the oppressed and the oppressors. This aim excludes all the paternalistic, charitable attitudes that belittle the human personality.

This ministry has at least three different facets:

1. *Prophetic ministry:* This is a responsibility the church has resolutely assumed throughout the ages and in the most difficult, dangerous political and social circumstances. In the field of health, the church has rightly drawn attention to the disparity between the resources available for health care and the amount of money invested in industry, research and technology for military purposes. The church must never forget the dangers that can render its prophetic ministry ineffective:

a) limiting its activity to mere denunciation without actually committing itself to the quest for feasible, effective solutions;

b) issuing denunciations on the strength of emotional reactions without being thoroughly informed about a subject, without proper scientific, technical and political advice;

c) restricting the amounts allocated to health and education-related plans and projects in church budgets themselves.

2. *Diaconal service:* Frequently the church carries out diaconal work in the health sector either without any clear-cut policy, or else in accordance with an institutional policy.

a) *In the absence of a policy,* needs are defined on a purely emotional basis or as a result of

lobbying. There are no guidelines for assigning priorities and energy is used in an irrational, uncontrolled manner to seek funds. Work is largely inefficient and ineffective as a result.

b) *According to an institutional policy,* the goals of hospital-institutions, school-institutions or other similar entities take precedence over the needs of the people. Resources are channelled into the working of a pre-existing infrastructure, and the health situation outside the institution is totally ignored.

Diaconal service should involve the setting of health objectives for the entire population within the framework of a global social policy aimed at increasing the level of wellbeing and the quality of life for all.

The church should play a part in the formulation and implementation of government policies; it must also devise and carry out its own health policies.

3. *Stewardship:* The church is responsible for managing the resources available for its ministry according to moral standards and ethical principles and also in such a way as to meet the detected, felt needs of the most marginal, backward segment of society.

Health activities have a price, both in terms of the monetary value of resources, equipment and manpower and in terms of all the economic consequences of disease.

V. PRESENT SITUATION IN THE FIELD OF HEALTH

We are presently witnessing the beginnings of a salutary humanitarian reaction against the type of medicine that lacks respect for the human person, wields its power arrogantly, closing its eyes to the intolerable injustice in health.

A return to natural sources and recognition of medicine's limited ability to create the conditions for humankind to develop its full creative potential is being advocated.

W.L. Barton, acting Programme Manager of Staff Development and Training at WHO headquarters, feels that Alma-Ata heralds a *new era* for the health sciences, marking the end of the clinical science and even the public health science eras and the beginning of the political health science era, characterized by:

a) a philosophy: people-centred

b) a purpose: diagnosis and treatment of the total body politic

c) an education: based on social experience learning, social and economic understanding, managerial acumen, a political process, and country health programming

d) research: centred on social and economic indices for health development, subjective indices for the quality of life, intersectoral activity processes and network processes

e) an interrelationship: with the behavioural sciences (social, health, economic and political sciences) by means of intersectoral teams.[7]

The Declaration of Alma-Ata sets the goal of an acceptable level of health for all the people of the world by the year 2000. After pointing out the most salient features of the existing inequality in the health status of the people, it affirms that primary health care is the key to attaining this target as part of development in the spirit of social justice.

The conference stresses the responsibility of all governments to promote and preserve the health of their people and urges "the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in the developing countries".

International governmental organizations, national governments and their health ministries, and NGOs have formally expressed their commitment to these goals and strategies.

The church must become aware of, and play an active role in, this concerted effort to put primary health care into practice on a global level.

VI. NEED FOR A HEALTH POLICY

One of our criticisms of diaconal health care service was the lack of a health policy. This criticism also applies to government bodies in many countries, where the situation is compounded by the lack of continuity in the activities undertaken; as a result, surveys already

carried out are repeated, efforts duplicated and time and resources wasted to the detriment of the people.

Activities in the field of health cannot possibly bear fruit unless their purpose is quite clear. The role of a health policy is precisely:

a) to define the problem once the entire situation has been assessed from a certain distance;

b) to identify the ultimate goal, reflecting commitment to a vision or philosophy (which we shall call the "image-horizon" or "image-object").

At the Alma-Ata Conference, the problem was defined as being that the vast majority of the world's population has no access to basic health services (Diagram 2); the image-horizon was identified as the imperative to extend health service coverage until everyone has permanent access to suitable, effective integral care (as regards treatment, rehabilitation, prevention and health promotion). (Diagram 3)

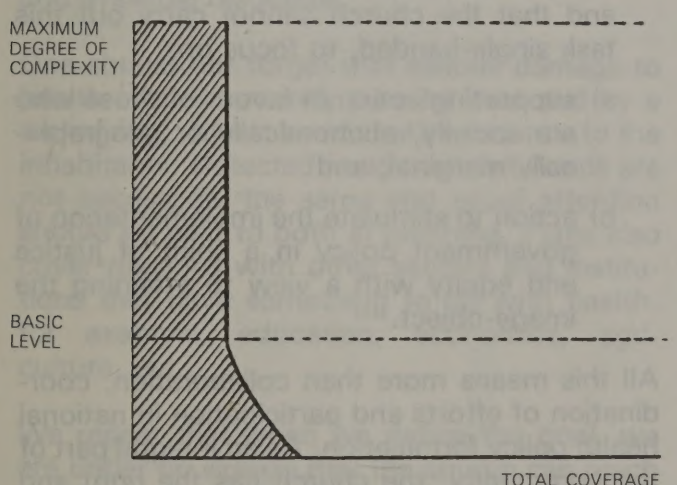


Diagram 2

Present situation: the vast majority does not have access to any permanent form of health care or even to basic services. Resources are invested to achieve a maximum degree of complexity available to very few.

The countries taking part in the Alma-Ata Conference declared that "a main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

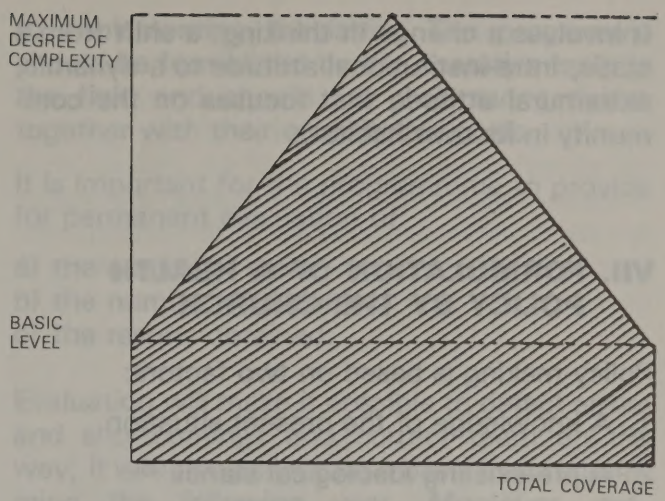


Diagram 3

Image-horizon: permanent coverage of the entire population by the basic health care services (preventive, curative and promotive). At the same time, the most complex facilities/technology is regionalized, thereby ensuring that everyone has access to them when necessary.

Once the policy has been defined, it is unwise to move straight on to action. It becomes necessary to analyze a series of factors and variables that will have a negative or positive influence on the process of attaining the image-horizon. This is why another key component — *the strategy* — has to be defined or the policy will remain a dead letter.

We maintain that the most suitable strategy for achieving the above-mentioned goal at this time is *primary health care.*

It is a philosophy for action and an organizational model that makes for the fullest use of all the positive variables and neutralizes the negative variables.[12]

A philosophy for action because it tries to achieve self-reliant individual, family and community health care and participation in the planning and operation of health care. It is designed to bring about self-reliance and self-determination (self-management) by means of education and the delegation of responsibility and duties.

An organizational model because it provides for broad contact between the health services and the community so everyone receives suitable, relevant treatment whenever necessary; it is designed to bring health care as close as possible to where people live and work; it is based on proper regionalization and a rational scale of complexity so all have access to what they really need.

It involves a change in thinking; a shift from a static, intra-institutional attitude to a dynamic, extramural attitude that focuses on the community in its own habitat.

VII. FORMULATION OF A HEALTH POLICY BY THE CHURCH

Policy-making is based on two factors:

1. A knowledge of the present situation.
2. A pre-existing ideological stance[13].

The first is the trigger mechanism that pushes the decision-maker to *do something.*

The "what to do" and "why" will be decided according to the second factor.

A country's government may react differently to the state of ill-health in a given region and the lack of coverage of a large sector of the population depending on its ideology: it may decide to improve the situation as far as possible, to make some improvements, to prevent further deterioration, or to do nothing and let things take their natural course. Emphasis may be placed on government action in the field of health or education, or on the development of roads, energy or some other network, thereby making it necessary to limit the health budget in the belief that health will benefit indirectly from such measures.

It is worth noting that the policy may or may not be explicit. Moreover, other values may determine government action, such as nepotism, or furthering the interests of powerful groups or sectors.

A private enterprise will also adopt its policy on the basis of a critical analysis of the existing situation, and will define its goals in keeping with its materialistic, profit-oriented ideology.

The church is part of the world community and hence the national community. If it is aiming at integral human promotion, it must become aware of the present situation in the health sector. This knowledge will also galvanize it into action. The ideological justification must be sought in theology. We spoke at the beginning of its tradition of service in the field of health care and the central theme of Biblical thought, summed up in constant love for one's neighbour.

The church's role in each place is to clarify the meaning of *human promotion* and *love for one's neighbour* in terms of health. To do so, it is necessary to make a critical analysis of the present situation of community health, the image-horizon of government policy, and the image-horizon of church policy.

We analysed the present health situation in section V and concluded that church objectives presently coincide with worldwide objectives. It is therefore up to each national church to act as a driving force behind this policy to achieve basic coverage of the entire population, thereby overcoming the existing situation of injustice.

We propose that for its service in the field of health, the church adopt a policy along the following lines:

1. Set the goal of justice in health in the form of basic coverage for the entire population in its community ecology.
2. Adopt primary health care as the strategy.
3. Mindful of the fact that "governments have a responsibility for the health of their people" and that the church cannot carry out this task single-handed, to focus on:
   a) supporting action in favour of those who are socially, economically or geographically marginal; and
   b) action to stimulate the implementation of government policy in a spirit of justice and equity with a view to attaining the image-object.[14]

All this means more than collaboration, coordination of efforts and participation in national health policy formulation. As an integral part of the community, the church has the right and duty to contribute to the search for feasible solutions to the major problems affecting the population of each country.[15]

"Formal" health policy will coincide with the "real" policy providing the necessary allocations are made in the budget. The church should not only learn to uncover the government's "real" policy but also to be sufficiently self-critical to analyze what its own budgets are saying.

VIII. HEALTH PLANS, PROGRAMMES AND PROJECTS

These are means and should never constitute ends in themselves.[16] It is most regrettable to

see organizations get lost in an expensive tangle of unending plans and programmes. They seek such perfection that they never find the time nor the strength to take action.

1. **Plans**

Planning involves analyzing the present situation as accurately as possible and defining the ultimate goal (or "image-horizon"), that is to say, the medium (3 to 5 years) or long-term (10 to 20 years) goal. In the planning stage, this image-horizon is sharpened by a few technical questions relating to the *time* it will probably take to achieve, the *place* where activities will be carried out and the *persons* who will constitute the target population.

In addition to pointing out "where we are" and "where we wish to end up", the plan should specify what major resources are, or are expected to be, available and which activities should be carried out first in order to attain the goal. These priorities should be assigned in accordance with the degree of ill-health, its importance for the community and the feasibility of solving the problem with existing know-how and available resources.

One should not forget that serious damage to health in a community may be detected by a technician, yet not be of vital importance to the inhabitants. Detected needs and felt needs are not necessarily the same and equal attention should be paid to both in planning. Plans also cover relations with other sectors and institutions that have something to do with health, for example, education, economics, agriculture, etc.

We repeat that when we define the goal, we are under no illusion that the church can reach it single-handed. The church must have its own plan to specify its contribution and the way in which it can speed up the process of change.

In short, planning is also a decision on strategy taken in accordance with the guidelines set out in the policy. It is the instrument for carrying out this policy.

2. **Programmes**

The programme is the tool that enables us to carry out the plan. Programming covers a limited period of time — no more than one year.

A series of decisions on tactics rather than strategy are now gone over in detail with a view to implementing the latter. The programme should be formulated by the operative team in the field and should list projected activities together with their quantitative goals.

It is important for the programmme to provide for permanent evaluation of

a) the quality of work,
b) the number of activities,
c) the results obtained.

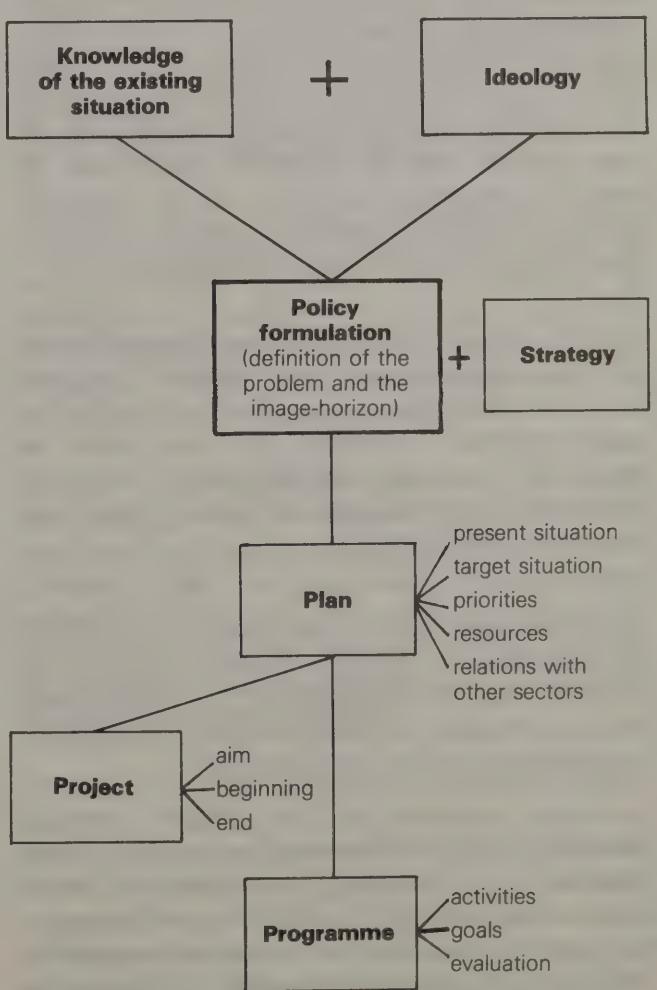
Evaluation will make it possible to detect errors and shortcomings and correct them on the way; it will also constitute a basis for programming the following year. Moreover, programme evaluation is the first step in assessing plans and policies.

3. **Projects**

Projects are simply programmes with a very concrete aim. They are characterized mainly by the fact that they are of limited duration. Pro-

Diagram 4

Methodological diagram for formulating a health policy and drafting plans, programmes and projects.



jects may involve the construction of a health centre, the creation of a radial communications network, the provision of piped drinking water in a village, etc.

Diagram 4 sums up the most salient features of this methodological process which starts with the formulation of a policy and finishes with the implementation of a programme.

IX. DANGERS OF DOMINATION AND DEPENDENCE

Depending on how the church carries out its ministry, it is either fulfilling its mission of redemption or, on the contrary, leading the community into a state of oppressive dependence. We shall comment on a few situations that illustrate what we have just said.

When work is undertaken without a clearcut policy, activities are an end in themselves since they grow out of an urge to "do something for the sake of doing it". The community merely "receives" a service provided by a "field team" with no clear objectives or strategy without, moreover, any additional thought being given to consistency or continuity. The community is a passive entity. This team and its work depend in turn on the flow of funds sent by a church with means of its own or largely raised abroad. This church has no in-depth knowledge of what is being done nor why, as its motive in making gifts is to appease an uneasy collective conscience about those in greatest need.

There is, moreover, the risk that these activities will gradually become "disconnected" not only from the theological line of the church that supports them financially, but also from the local and national context itself, owing to the lack of continuous reflection by all the members. (Diagram 5)

The field team may receive financial assistance directly from a foreign church, pushing the national church increasingly to the sidelines and heightening the community's dependence on outside support. (Diagram 6)

Another situation that also involves the risk of domination is what might be called the "technocratic approach". A selected or self-appointed group of persons get so carried away with planning and the techniques of administrative

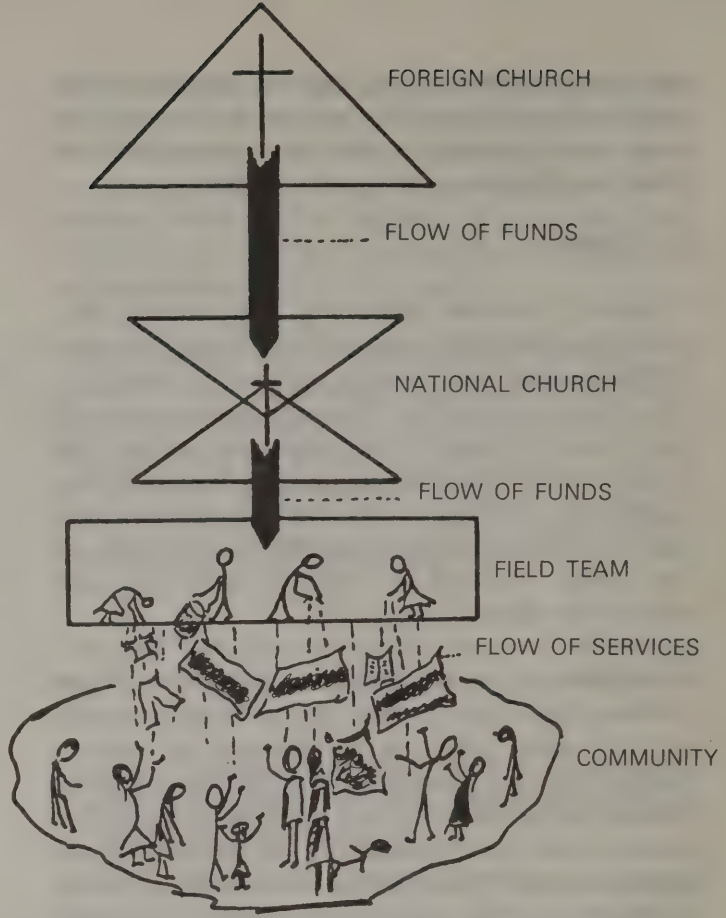


Diagram 5

Chain of dependence: the national church depends on the flow of funds from abroad, the field team on the national church; the community passively receives the services. The national church neither becomes aware of the problem nor participates. Work becomes increasingly far removed from theological thought and the local and national context.

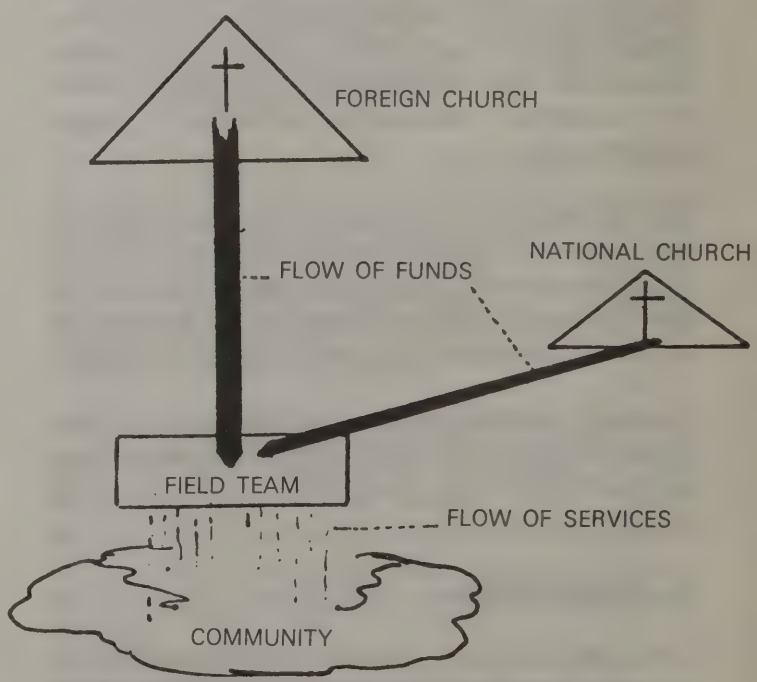


Diagram 6

A different type of dependence: the field team receives funds directly from abroad, relegating the national church increasingly to the side-lines.

organization that they forget they are tools for attaining a goal and not ends in themselves. Policies are thus formulated and plans drafted in the absence of reflection by the members of the church, who do not have an opportunity to become familiar with the problem or to make a contribution; nor does the community — which is the supposed beneficiary of these services — participate in any way. Objectives and priorities that fail to reflect the community's felt needs are set and decisions are taken for the community. Unrealistic goals are fixed, causing subsequent frustration. The church passively receives some information together with demands for funds that may be partly its own and come partly from abroad. They may also be sent directly by the foreign church as in the preceding case. The field team in turn receives the order to carry out an imposed programme. The channel of communications is totally vertical: it receives orders and sends information. (Diagram 7)

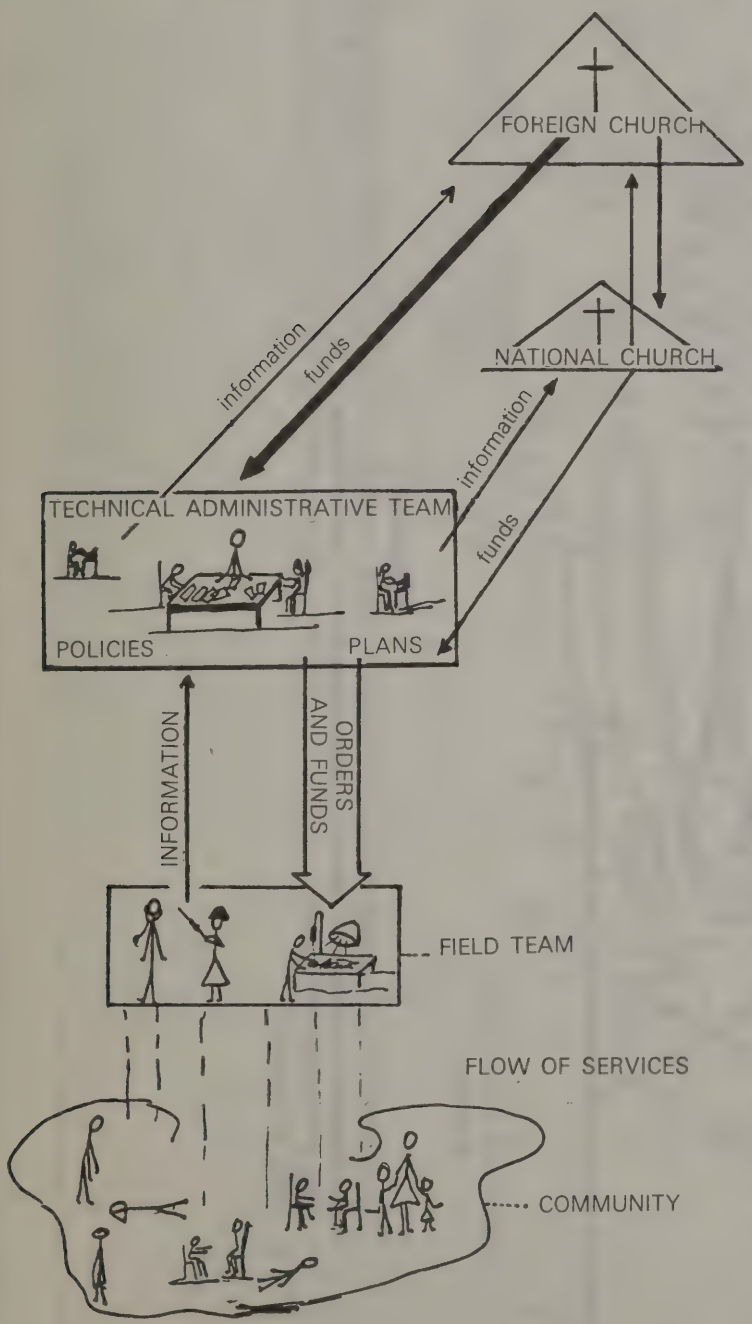


Diagram 7

Technocratic domination: the church remains on the side-lines. The community passively receives the services. Communication is vertical: the technical/administrative team sends orders and funds; the field team returns information.

X. THE CHURCH MINISTRY OF SERVICE AS A TOOL FOR SALVATION

The church must continually announce the message of redemption and liberty in Christ. Its ministry of service seeks a human life for each individual who has been created by God with "possibilities of liberty, creativity and love, which were fully realised in Jesus Christ".[18]

In contrast to what was described in the preceding section, we shall now outline a model for a horizontally organized service to promote self-management and self-reliance.

The church makes active contact with the community and becomes immersed in it. It sees its face, *knows* and *feels* its needs. This leads to the decision to undertake a health care ministry and simply reflects the desire to do something, the goal and how to attain it.

The second step in this approach consists in seeking more specific information about the existing health situation, and drafting an outline of a feasible, medium-term goal. This entire process involves the continuous participation of the community itself and the members of the national church.

Once the geographical area and the target population of the action have been defined and the main resources pinpointed, the health plan is ready. Priorities have been chosen with a complete knowledge of what the community feels and needs. The national church can now appeal for support to the world Christian community's sense of solidarity.

At this point, the field team formulates its programme, decides on the technical tactics required to meet policy aims and plan objectives. It will bear in mind the fact that the strategy is primary health care. The human resources therefore comprise not only the members of the team, but also the entire community. This

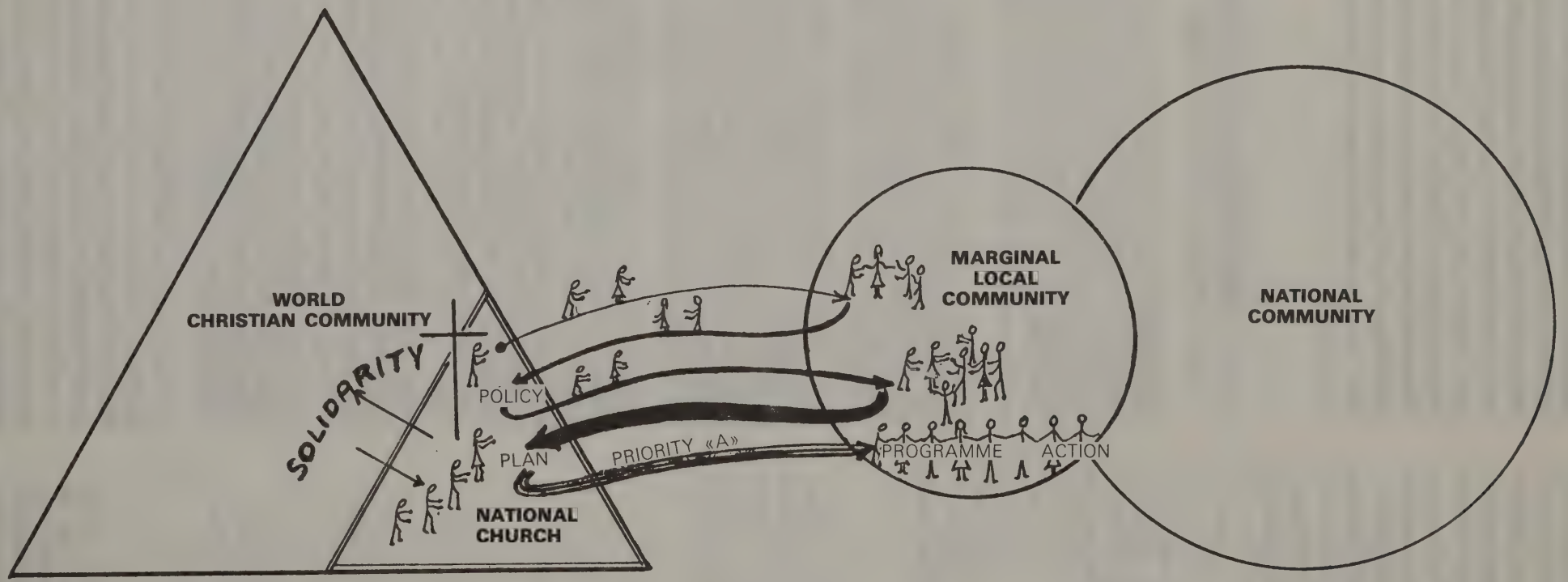


Diagram 8

Operative horizontal model (phase 1): the national church becomes immersed in the marginal local community and with it formulates a policy and drafts plans and programmes. The church carries out supportive activities with the community and at the same time seeks to mobilize local and national resources. The world Christian community participates in a spirit of solidarity.

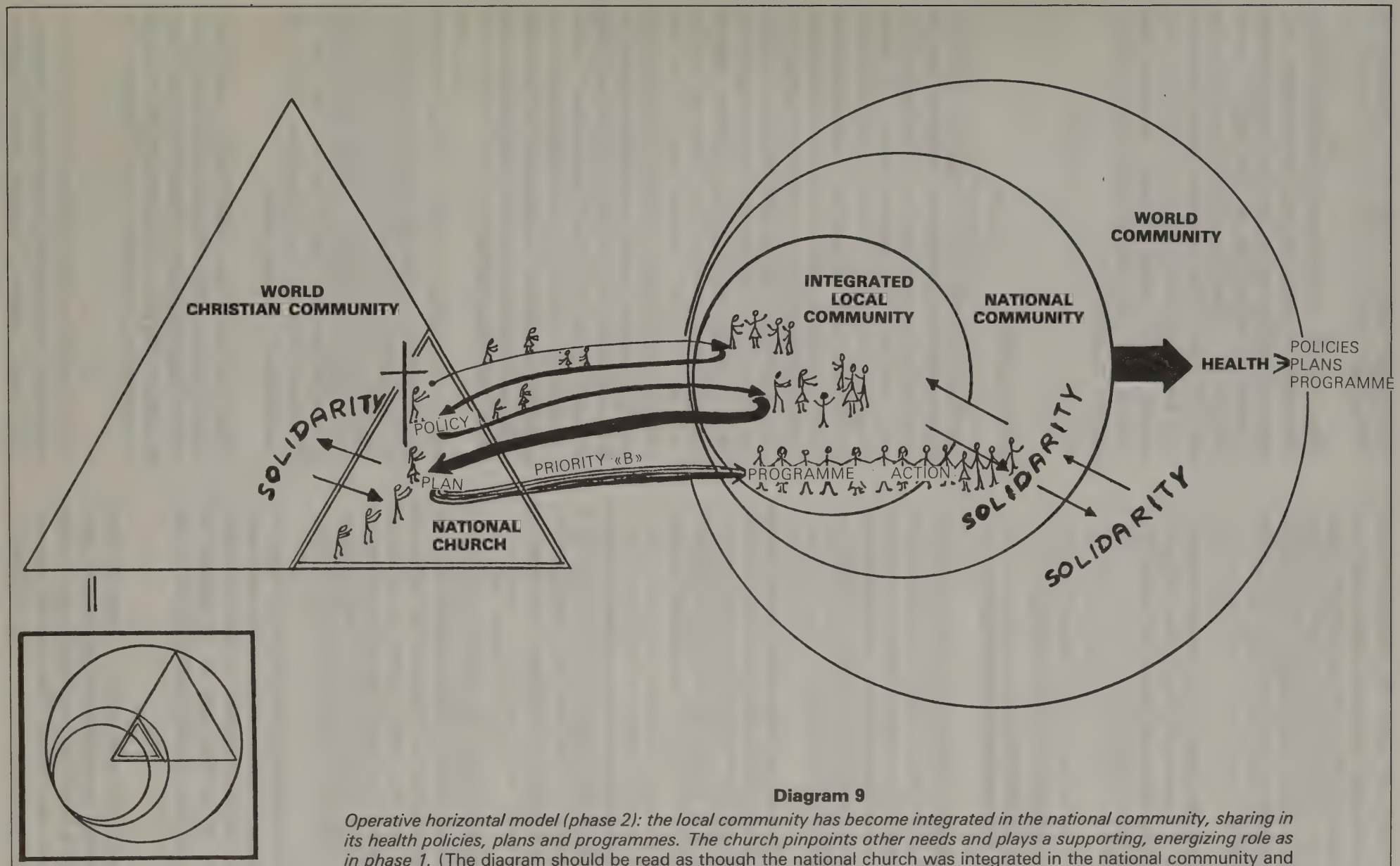


Diagram 9

Operative horizontal model (phase 2): the local community has become integrated in the national community, sharing in its health policies, plans and programmes. The church pinpoints other needs and plays a supporting, energizing role as in phase 1. (The diagram should be read as though the national church was integrated in the national community and the universal church in the world community. See miniature diagram).

is why it will call upon the teacher, priest, pastor, policeman, parents, etc. and train health promotors from the community itself. (Diagram 8). This model for full community participation that we call operative horizontalization is what we also advocate for government action.

What then is the church's future in the field of service? If it remains faithful to the Gospel, it will always be present, playing a supporting, energizing role. (Diagram 9)

XI. THE CHURCH AND ITS ROLE IN AWAKENING AND ORIENTING VOCATIONS

The church has a great deal to do in this area. Vocations have not only to be awakened but also oriented in a spirit of love, service and dedication to one's neighbour, and in the sense of the whole person in his/her bio-physical and socio-economic environment.

The church has an educational task to accomplish among those of its members who go through university. It must keep before them the precepts of respect for the human person, justice and human dignity as against science-worship.

The church should alert its members to remain critical of approaches whereby the individual is seen as an object, identified by a bed number, considered a mere case study or experimental material.

Although we maintain that all the members of the church contribute to Christian service in the field of health, there is no denying that those who work in the health sector bear special responsibility in the way in which they go about their daily task and also in their contributions to policy formulation and the drafting of plans.

The church should support and encourage the participation of these members in government-run public health activities in order that they may play an active part in a process of humanisation and growing justice within these services.

Church members who work in these services are constantly tempted by a competitive society to satisfy economic and intellectual desires rather than real needs. The church has an educational task to carry out. The vocation to serve should exist not only during training but throughout life.

"The church should remind its youth of the possibility of social service, humanitarian and health vocations which should be undertaken in a spirit of self-denial and dedication to one's neighbour." "There is also a labour of justice and of reparation to be accomplished to ensure that the marginalized strata of our society has access to the means of health, because this reflects God's will, His preference for the poor and the forsaken." (20)

CONCLUSION

Injustices in health call for a response from the church. The church should adopt a way of thinking that leads it to act *with* the people, ridding itself of the superior feeling of doing things *for* the people. It must first be in solidarity with the local, national and world community. The Christian ministry of service is the ideal way to do this. Moreover, diaconal service provides the best opportunity for the church humbly to acknowledge sin and the scandal of division and to build the bridges that lead to unity in Christ.

The church's decision to undertake service outside its places of worship should be rooted in the reflection of its members and expressed through each Christian community's own channels. In this way, plans and programmes will have solid bases made up of the Christians who have become aware of their personal and communal responsibility.

We can no longer live with the idea that the church carries out its ministry in any old way. On the contrary, the church must use all the available scientific and technical knowledge to make its work exemplary. Nor can we continue to tolerate false ministry of service used overtly or covertly like a bribe to lengthen the list of members of a congregation.

Once the church has a health policy, and a permanent process for reflection and policy revision to keep pace with constant change, it can be sure of carrying out its ministry of service in a dependable, responsible way. (Diagram 10)

The demonic powers-that-be have their own policy with patently anti-human aims; exploitation, wars, violence, hunger, use of science

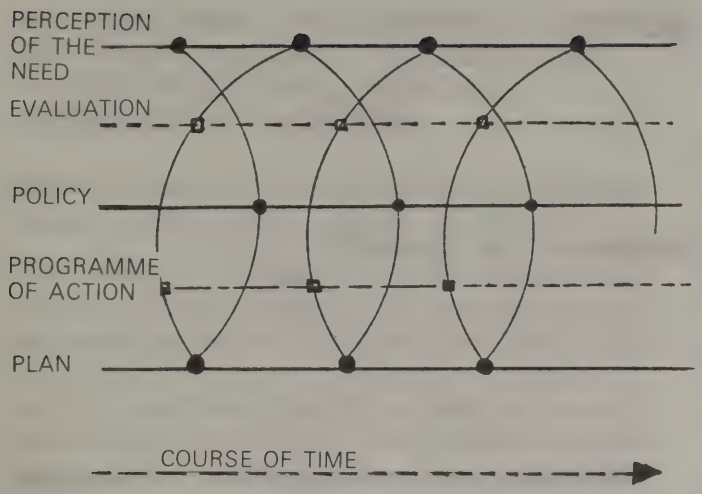


Diagram 10

Permanent process of evaluation and reflection: thanks to which policy, plans and programmes are constantly reshaped in accordance with changing situations in each place and time.

and technology to serve sectoral interests and the pollution and destruction of the biosphere are some of its concrete manifestations. Constant reformulation and coherence are the main features of this de-creative policy. Thus, the church cannot shirk its responsibility towards millions of people and their future. Service is the church's best channel of action. In meeting the basic health needs of the people and working towards total coverage, the church will acquire deeper knowledge, the authority and moral stature of a prophetic voice that is listened to and respected. Diaconal service is also the best way to attain its objectives of supporting, teaching and encouraging self-management and the equitable distribution of resources.

Faced with the intolerable situation of global inequalities in the health sector, the church now has the opportunity of moving into the breach already opened towards justice in health.

■

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27th INTERNATIONAL SEMINAR ON LEPROSY

27th International Seminar on Leprosy

September 12-18, 1982

Purpose:
To provide an up-to-date review of clinical leprology and leprosy control.

Intended for:
doctors, nurses and paramedicals planning to work or already at work in countries where leprosy is endemic.

Programme:
Specific seminar objectives will be developed as soon as participants register, focusing on their particular requirements.

Workshop on management of leprosy training

September 20-24, 1982

Purpose:
To introduce participants to a modern systematic approach to training paramedicals and others for leprosy work, to enable them to make their own training programmes more effective and enjoyable.

Intended for:
Any who participate in the leprosy seminar and expect to be actively engaged in training others.

Programme:
The Workshop will be led by Dr W.F. Ross who has wide experience in Africa and Asia and is a contributor to the WHO supervision manual "On being in charge". Extensive use will be made of the National Hansen's Disease Center's training resources.

Administrative arrangements for both seminars

Place: National Hansen's Disease Center, Carville, Louisiana, USA.

Cost: Tuition, accomodation and board are provided free of charge. Participants must cover the cost of their own travel to New Orleans and return.

Transport: Participants will be met at New Orleans International Airport on September 12, 1982, at 3 p.m. There is no other transportation from airport to Carville.

Registration: Please send the following information as soon as possible, but *not later than August 1, 1982* to the address below:
Name; address; telephone; professional training (place, dates, degrees); previous experience in leprosy work; jobs you expect to be doing in the future; skills, knowledge and understanding you hope to gain from attending the course; name and address of mission or agency to which you are presently related.

Dr W.F. Ross
American Leprosy Missions
1262 Broad Street
Bloomfield, New Jersey 07003
USA

1982 TEACHING PROGRAMME AT THE TROPICAL CHILD HEALTH UNIT, INSTITUTE OF CHILD HEALTH, UNIVERSITY OF LONDON

M.Sc. Course in Mother and Child Health
Duration: 15 months. October to December

This course is designed for future teachers of mother and child health for medical schools and auxilliary training institutions in Third World countries. The course programme consists of lectures, seminars, individual projects, presentations and essays, field work in an innovative programme, usually in a developing country, and preparation of a dissertation. The topics covered include:

- child bearing
- child rearing
- nutrition and feeding
- growth and development
- communicable disease control
- teaching and training of workers in primary health care
- acute illnesses and emergencies
- epidemiology and statistics
- MCH service provision, resources and evaluation.

Special emphasis is placed on the part communities can play in their own health care.

Further details are available in the course prospectus, obtainable from:

M.Sc. Course Secretary
Tropical Child Health Unit
Institute of Child Health
30 Guilford Street
London WC1N 1EH / UK

Paediatric Priorities in Developing Countries

Duration: 1 week (July 1982);
2 weeks (September 1982)
1982 theme: "Communication in Primary Health Care"

These courses have been run for over fifteen years and are open to doctors, nurses and others in the health care field who work or are intending to work in a developing country. In both courses, the priority problems of child health are examined. Each day, there are two or three lectures, but time is also spent in small group discussions, drawing on the experience of members of the course.

Details from:

Short Courses Secretary
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Health Care Planning and Provision for Mothers and Children
Duration: 1 week (June 1982)

This course will focus on issues facing the district health team in planning and provision as well as evaluation of mother and child health care. Each day will start with a lecture introducing concepts and new tools for describing the pattern of disease in the community, the recognition of high-risk individuals and communities, the identification of district resources and the provision of services and evaluation of mother and child health care. Discussion groups follow up on topics raised in the opening lecture and the afternoons are spent in case study exercises.

Details from:

Short Courses Secretary
Tropical Child Health Unit
Institute of Child Health
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London WC1N 1EH / UK

Training Opportunity in Maternal and Child Health

The Graduate School of Public Health, San Diego State University, San Diego, California, USA, is now accepting applications from obstetricians and paediatricians interested in a career in the field of maternal and child health. Applications are being accepted for *August 1982*. The Training Programme is of nine months' duration. Considerable effort is made by the Faculty to assist each student in career planning.

Inquiries should be addressed to:

Helen M. Wallace, MD
Professor and Head
Division of Maternal and Child Health
Graduate School of Public Health
San Diego State University
San Diego, CA 92182
USA

One of the major activities of the **International Children's Centre** in Paris is the preparation and dissemination of information concerning health and health-related problems of children, adolescents and the family. The *"Courrier"* and *"Children in the Tropics"* are two of their several regular publications.

Another ICC publication, the **Technical Reviews**, is intended for the use of doctors and other university-level health professionals, nurses, midwives, social workers, teachers, parents, planners, administrators, policy makers and mass media specialists.

In the *Technical Reviews,* practical and educational material on a number of specific topics is presented. The series has so far covered the folowing topics:

– breast feeding – infant stimulation – immunizations – accident prevention	1979
– abused children – infant nurseries and day care – early screening of handicaps and social integration of handicapped children	1980
– dental caries and prevention – early malnutrition: prevention and treatment – prevention of high-risk pregnancy	1981

The *Technical Reviews* are published in English, French and Spanish. They may be reproduced or translated into other languages and used as a source of information for radio and/or TV programmes, articles or other documents, provided the source of the document is mentioned and the ICC informed.

For further information, please write to:

Dr Paul Vesin
Director
ICC/H/HS Programme on the
Development of Information
on Early Childhood
International Children's Centre
Château de Longchamp
Bois de Boulogne
F-75016 Paris
France

* * *

Vaccine Cold-Chain Information Sheets

Health workers carrying out immunization programmes often work in temperatures of 40°C or more. Since vaccines quickly lose their potency if stored or transported under such conditions, it is essential to maintain an uninterrupted cold chain from manufacturer to user. WHO's Expanded Programme on Immunization has produced a series of information sheets on all aspects of the vaccine cold chain. The following sheets are now available *free of charge:*

- Product Information Sheets (SUPDIR 55 AMT.3) — French, English and Spanish
- Testing Voltage Regulators for Vaccine Refrigerators and Freezers (EPI/CCI/80.3)
- Vaccine Hand Carrier and Cold Box Testing (EPI/CCI/81.3)
- Vaccine Refrigerators and Freezers — Summary of recent Tests. (EPI/CCIS/81.6)
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- Vaccine Cold Chain Monitor (How to check if vaccines have been kept at the correct temperatures). (EPI/CCIS/81.8 and EPI/CCIS/81.10)
- Organising and Running a Course on Compression Refrigerators for Repair Technicians (EPI/CCIS/81.12)

Inquiries and requests should be directed to:

Appropriate Health Resources and
Technologies Action Group
(AHRTAG)
85 Marylebone High Street
London W1M 3DE / UK

* * *

For congregations and groups interested in reflecting on the different dimensions of the church's and congregation's ministry of health and healing and how it can be put into practice, a study kit entitled **Health for Life,** jointly produced by the Churches Council for Health and Healing in London and the Oxford Institute for Church and Society, will be a useful base for group discussions as well as individual study. The kit comprises eight sections, each from a different contributor: *What is Health?; Health and the Kingdom of God; Health, Suffering and Salvation; Prayer, Healing and Sacraments, Fulness of Life; The Health Service; Eco-Health; Songs, Prayers and Readings.*

Price (without postage): Single copies £ 1.25
5 copies £ 5.—
10 copies £ 9.—

Inquiries and requests should be addressed to:

Churches Council for Health & Healing
St Marylebone Parish Church
Marylebone Road
London NW1 5LT / UK

or

Oxford Institute for Church and Society
25 Aston Street
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* * *

Medical Laboratory Manual for Tropical Countries, by Monica Cheesbrough
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This excellent manual, intended to train laboratory technicians working in hospitals in developing countries, provides a very comprehensive, finely illustrated coverage of current information on anatomy and physiology, medical parasitology, and clinical chemistry for laboratory technicians, as well as information on the preparation of reagents, the addresses of manufacturers, pocket-size S1 unit conversion tables, a sheet of self-adhesive biohazard labels, a table of blood and urine test results to investigate liver disorders, and charts to diagnose malaria parasite species and microfilarie.

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